Today's Date: _____

Name: _____ Date of birth: _____

Are you under the care of any other doctors or health providers? Yes No

Whom: _____

Do you have any of the following health problems or symptoms? Please check yes/no and explain or indicate any other health issues below.

Yes	No		Yes	No	
☐		Weight gain [_____lbs]	☐	☐	Headaches/migraines
☐		Weight loss [_____lbs]	☐	☐	Vertigo/dizziness
☐	☐	Fever/chills	☐	☐	Weakness
☐	☐	Night sweats	☐	☐	Neuropathy
☐	☐	Loss of appetite	☐	☐	Fainting
☐	☐	Abdominal pain	☐	☐	Seizures
☐	☐	Heart burn/reflux	☐	☐	Stroke
☐	☐	Ulcers			
☐	☐	Liver disease	☐	☐	Cough
☐	☐	Hepatitis B or C	☐	☐	Bloody sputum
☐	☐	Nausea	☐	☐	History of tuberculosis
☐	☐	Vomiting	☐	☐	Shortness of breath
☐	☐	Diarrhea	☐	☐	Asthma
☐	☐	Constipation	☐	☐	Emphysema
☐	☐	Pain/bleeding with BMs			
☐	☐	Hemorrhoids	☐	☐	Heart disease
☐	☐	Bowel disease	☐	☐	History of a heart attack
☐	☐	Had a colonoscopy [Year_____]	☐	☐	High blood pressure
			☐	☐	Palpitations/arrhythmia
☐	☐	Painful urination	☐	☐	Pacemaker or defibrillator
☐	☐	Blood in urine	☐	☐	Heart murmur
☐		Prostate enlargement	☐	☐	Chest pain
☐	☐	Urinary incontinence	☐	☐	Leg swelling
☐	☐	Kidney disease	☐	☐	Leg pain/poor circulation
☐		Vaginal bleeding/discharge	☐	☐	Varicose veins
			☐	☐	Leg ulcers
☐	☐	Eczema			
☐	☐	Psoriasis	☐	☐	Neck/back pain
☐	☐	Skin cancer	☐	☐	Joint pain
			☐	☐	Arthritis
☐	☐	Had a mammogram [Year_____]	☐	☐	Gout
☐	☐	Anxiety	☐	☐	Swollen glands
☐	☐	Depression	☐	☐	Anemia
☐	☐	Sleep Disorder	☐	☐	Bleeding tendency/disorder
			☐	☐	Cancer: type(s)_____
☐	☐	Corrective Lenses			_____
☐	☐	Visual Changes	☐	☐	HIV/AIDS
☐	☐	Cataracts			
☐	☐	Glaucoma	☐	☐	(Heat)/(cold) intolerance (circle)
☐	☐	Difficulty swallowing	☐	☐	Excessive thirst
☐	☐	Hoarseness	☐	☐	High cholesterol
☐	☐	Hearing loss	☐	☐	Diabetes
☐	☐	Sinus problems	☐	☐	Thyroid disease
☐	☐	Environmental allergies			

Please explain: _____

_____